



AUTHORIZATION REVOCATION

State Form 52114 (5-05)

**INDIANA STATE DEPARTMENT OF HEALTH
OFFICE OF HIPAA COMPLIANCE**

“This agency is requesting the disclosure of your Social Security number in accordance with IC4-1-8-1. Disclosure is voluntary and you will not be penalized for refusal.”

**CONFIDENTIAL INFORMATION
per 45 CFR 164.508**

Purpose: This form is used to revoke or to confirm revocation of an authorization previously given.

SECTION A: Individual revoking the authorization.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

SECTION B: Individual’s statement of revocation.

I revoke my authorization for the use and/or disclosure of the protected health information described in the authorization *(or below, if the authorization is not attached)*.

I understand that this revocation will *not* affect any action you or others took in reliance on my authorization before receipt of this written revocation. I also understand that, if my authorization was a condition of my enrollment in a health plan, of my eligibility for benefits, or if my receipt of health care to create protected health information for a third party, you may disenroll me from the health plan, end my eligibility for the benefits, or not provide for the health care.

Copy of authorization attached: Yes. No *(complete Section C)*.

SECTION C: Description of authorization revoked (complete if authorization not attached).

Date of authorization *(if known)*: ____/____/____

Protected Health Information Affected: The revoked authorization applied to the following protected health information:

Entities Authorized to Use or Disclose: The revoked authorization allowed use and/or disclosure of the protected health information described above by the following persons and/or organizations *(or classes of persons and/or organizations)*, including us:

Entities Authorized to Receive and Use: The revoked authorization allowed the protected health information described above to be received and used by the following persons and/or organizations *(or classes of persons and/or organizations)*, including us:

INDIVIDUAL'S SIGNATURE

Signature: _____ Date: _____

If this revocation is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION REVOCATION AFTER YOU SIGN IT.

**Send to:
Privacy Officer, Office of HIPAA Compliance
Indiana State Department of Health
2 North Meridian Street, 3K
Indianapolis, IN 46204**